

**Department of Mental Health (DMH)  
Mental Health Services Act (MHSA)  
Stakeholder Input Process**

**General Stakeholders Meeting #5**

**Tuesday, April 25, 2006 in Orange, California  
Wednesday, April 26, 2005 in Sacramento, California**

**Meeting Summary  
For Discussion Only**

**I. Background**

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another in leading to a transformed culturally competent mental health system. This is reflected in the California Department of Mental Health's (DMH) *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

The general stakeholder meetings on April 25 and 26, 2006 were the fifth set of general stakeholder meetings for MHSA. The April 25 meeting in Orange, California and the April 26 meeting in Sacramento, California used the same agenda to provide the opportunity for stakeholders in two geographic regions of the State to review the status of the MHSA and to provide additional feedback to DMH about the Education and Training component and about the Community Services and Supports (CSS) Annual Update.

One hundred twenty-three people attended the morning meeting April 25 and 97 attended on April 26 for a total of 220 stakeholders. This summary reflects the combined content, questions and comments from both the April 25 meeting and the April 26 meeting.

## **II. Meeting Purpose**

The purposes of the general stakeholder meetings on April 25 and 26, 2006 were to:

1. Provide updates on MHSA progress
2. Solicit feedback on the Education and Training component
3. Solicit feedback on CSS Annual Update requirements.

## **III. Welcome, Introduction and Purpose of the General Stakeholders Meeting**

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, welcomed the participants to the fifth set of general stakeholders meetings. She described the purpose of general stakeholder meetings: they are meant to update the community about progress on MHSA at the state level in the previous six months. Feedback from participants would be solicited in three ways: through question and answer periods in the large group, small group discussions and written comments on the Education and Training Strategic Plan vision, mission, core values, goals and objectives.

Stakeholders came from the following areas: the Counties of Alameda, Contra Costa, Glenn, Kern, Lassen, Los Angeles, Marin, Mendocino, Monterey, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Barbara, Sonoma, Tulare and Yolo, as well as the City of Berkeley and Native American tribes.

## **IV. MHSA Progress and Updates**

Carol Hood, DMH Deputy Director, provided an update on various aspects of MHSA implementation.

### **A. CSS County Update**

As of April 25, 2006, 45 counties have submitted their CSS Three-Year Program and Expenditure Plans. Of those, seven have been fully approved and are beginning implementation, and between six and eight are expected to be approved by the end of April. The ten-member DMH evaluation teams have met with 44 of the 45 counties that have submitted plans. Some counties have not submitted their plans because of the length of their planning process. Some of the very small counties are finding that they do not have the human resources to put the plan together. DMH is working with them to help resolve this issue. DMH expected to complete the CSS proposal evaluation and approval process within 90 days. Between coordination of six teams of ten people,

review by Dr. Mayberg and the MHSA Oversight and Accountability Commission (OAC), the complexity of the issues, and extensive documentation by the counties, the time period has turned out to be closer to 120 days.

DMH is beginning work on the CSS Annual Update requirements, format and content, which will be discussed later in the meeting.

### **Stakeholder Questions and Comments**

- Are there timeframes when things will really start?
  - **DMH Response (CH):** It does take time to complete the approval process. Initially DMH thought approval would take 90 days, but it is taking 120 days. There are ten people on each team. The teams have a face-to-face meeting with each county. Then DMH typically asks for additional information, which takes time for the county to provide. Then DMH staff and the OAC provide a recommendation to DMH Director Dr. Mayberg. Sometimes approval is immediately granted and other times there are additional questions before final approval.
- The county plans do not cover the needs of Native communities.
  - **DMH Response (Carol Hood (CH)):** The OAC has a particular focus on Native communities. At each and every review, the review teams ask how Native communities were involved. Also the Department and Mental Health Directors meet regularly with leaders of the Native communities.
- Has the public looked at the tool used to review the plans?
  - **DMH Response (CH):** The tool is a re-organization of DMH Letter 05-05, the program requirements for CSS, with the same content, arranged for places to make notes and comments.

## **B. Prevention and Early Intervention**

Now that CSS is in the submission and approval process, other components of MHSA are beginning to develop more fully. The next two components are Prevention and Early Intervention and Education and Training. Jennifer Clancy, Executive Director of the OAC, and Dr. Roland Ives, DMH Deputy Director, made a brief presentation about Prevention and Early Intervention.

Ms. Clancy noted that there are two key question areas: governance and the Prevention and Early Intervention program itself. In terms of governance, the MHSA statute itself gives both OAC and DMH significant roles in development and implementation of the Prevention and Early Intervention component. The two agencies are working together. In terms of the program, questions include the following: What is the definition of prevention? What will the program actually look like? What are the priorities? How will it imbed cultural competence? When will the program roll out?

While there are no specific answers, the OAC and DMH are meeting weekly to address these issues. A combined staff workgroup is identifying questions and clarifying roles, with the intention of then sharing this information widely. The OAC's Prevention Committee is providing input. One of the strengths of the OAC is its charge to bring a broader group than the current mental health community to the table, just as DMH and the counties are charged with reaching as many unserved people as possible.

Dr. Ives echoed Ms. Clancy's comments about the collaboration between the OAC and DMH. He noted that the stakeholder process used over the past 18 months has had an enormous impact on OAC and DMH thinking in the area of prevention and early intervention. While the OAC and DMH will make decisions, stakeholder input is essential, especially on the issues of what populations will be targeted, what the problems are and the priorities for addressing them, what solutions will be implemented in the first three years and then in subsequent years.

### **Stakeholder Questions and Comments**

- How can stakeholders be heard on this issue?
  - **OAC Response (Jennifer Clancy):** The OAC and DMH are looking at the effective ways to ensure stakeholder input. The process will be influenced by the CSS stakeholder process. One suggestion is to hold regional hearings to provide feedback. Key documents for feedback will be posted on MHSA DMH and OAC websites.
- Everyone is aware of the positive effects of early diagnosis and intervention. What about prevention?
  - **DMH Response (Roland Ives (RI)):** This is a fundamental question. What is the appropriate balance between primary, secondary and tertiary prevention? One school of thought wants to focus on secondary and tertiary, to prevent severe mental illness from getting worse. But there is general agreement that there needs to be primary prevention. The vision over time is to shift toward more primary prevention. There has been no final decision about this.
  - **OAC Response (JC):** The OAC and DMH are committed to developing a stakeholder process. It will not be exactly the same as the CSS process, but there will be opportunities to have stakeholders provide answers to these questions of the right balance between primary, secondary and tertiary prevention.
- What are the boundaries for prevention: working with people waiting for their first break or trying to prevent people from getting back into the system or into the system in the first place? What will the priorities be?
  - **DMH Response (RI):** The OAC and DMH want to address all those areas. One of the key issues is how funds are allocated over time. Input from stakeholders is critical. For example, in the first three years, what are the priorities in terms of the different levels of prevention and to each of the age groups?

- Will prevention funding spread across all age groups?
  - **OAC Response (JC):** The decision has not been made. The OAC's Prevention and Early Intervention Committee has a broad spectrum of representatives, including people from NAMI, IRIS Foundation, etc.
  - **DMH Response (RI):** Rather than look at either end of the spectrum of complete state control or complete county flexibility in terms of requirements, DMH is hoping to reach a middle ground, with some statewide mandates which allow counties flexibility to take into account their individual needs.
- For people with first breaks, will services be considered early intervention or part of CSS?
  - **OAC Response (JC):** The answer is not known at this time.
- Will NAMI programs such as Family-to-Family be available for training at the college level and later in high school? This program has proven successful and should be replicated.
  - **OAC Response (JC):** This is a question for the Education and Training component.
- When will this component be rolled out?
  - **OAC Response (JC):** The specific timeline is not certain. The plan is to move forward with the goal of having program guidelines finalized by the end of 2006 or the beginning of 2007. This process may happen concurrently with the Education and Training component.
- Transformation needs to occur within the system. The problem of prevention is that there are sick people with post traumatic stress disorder (PTSD) living on the street, who are made sicker by the system. They are treated in ways that make their PTSD worse. Medication is not effective and harms people with PTSD. Rather than preventing sick people from doing things to make themselves well, transform to prevent the system from harming people. Prevent police and the mental health system from further traumatizing people.
  - **OAC Response (JC):** These are critical points. Together, stakeholders, DMH and the OAC need to work with the legislation and the counties to develop policies that will address these important societal issues.
- Because of the significant genetic component, if research allows providers to identify the components, first breaks could be prevented, which would be amazing.
- Part of the discussion about prevention should be to define "What is prevention?"

### **C. Capital Facilities and Housing**

Ms. Hood reminded participants that the first discussion about capital facilities and housing was begun by Darryl Steinberg, now chair of the OAC. He recognized that one of the major issues facing people with mental illness is housing. He suggested a

substantial, multi-billion dollar housing bond to address this. The Governor's Office has expressed an interest and is evaluating if it is feasible, or whether something similar can be done. Legal consultation has said that the bonds might not be feasible, but other options are being explored. DMH is working with the Governor on improving housing availability for people with mental illness. After this is resolved, DMH will be able to talk about broader capital needs.

### **Stakeholders Questions and Comments**

- Housing is a crucial component of mental health services. All of the methods discussed require significant time. The normal process is a difficult process. What are some creative ways to get housing for consumers, especially in rural areas?
  - **DMH Response (CH):** Some counties are using their one-time funds, of which there is about \$200 million. To date, counties plan to spend about \$58 million for housing through CSS plans and one-time funds. They are doing a variety of things: Housing Trust Fund, regional housing cooperatives, and training. DMH is working with the Corporation for Supportive Housing (CSH). The Governor's Homeless Initiative coordinates the efforts of various government agencies. The potential second phase of the Governor's Housing Initiative may have an estimated \$75 million each year for 20 years for housing. However, it is important to remember that addressing housing takes quite a bit of time. For housing for people with mental illness, it is also critical to bring the services, make sure it is affordable and then build it. Even with the best scenario, new housing will take three years.
- Include a section in housing programs for people who are at risk for losing housing. My rent went up \$100 per month, which was all my discretionary money. Because people with severe mental illness often do not have discretionary money, people are overusing credit cards and going into bankruptcy.
- Housing is so important for mental health clients. Every day consumers ask questions about housing. It is great that through MHSA there will be more housing.
- Housing for people with mental illness requires more than just average housing with a roof over their heads.
- Shelter Care Plus is an important program to expand.
- I have been very fortunate to live in a Homes, Inc. house and later in a HUD apartment. I would like to see more affordable housing for those with a mental illness who are not eligible for HUD housing yet.
- I am homeless and sleep beside the road. I wait for housing to be available.

## **D. MHSA Regulations**

When statutes such as MHSA are enacted, state government develops regulations that interpret the statutes. The first set of MHSA Emergency Regulations is now posted on the MHSA website for a 45-day public comment period. There will be a public hearing on these regulations on June 5, 2006 at 1 p.m. in Room 102, 744 P Street, Sacramento. Comments at that time or beforehand are welcome. Additional regulations will be released for public comment and public hearing as the regulations are developed. DMH will continue to inform people when these are released.

## **E. Information Technology (IT)**

The initial focus of IT has been to ensure the DMH's ability to accept county data on Full Service Partnerships and therefore has developed a Data Collection and Reporting System (DCR). DMH wants to invest money in electronic health records (EHR), to decrease time providers spend documenting services. EHR is also a vehicle for improving quality: it can highlight drug interactions, send reminders about lab work, health exams, etc. The IT Workgroup is now developing draft criteria for EHR functionality. DMH has between \$100 and \$200 million to invest in EHR and as a result can have a significant impact nationally on this issue.

## **F. Performance Outcomes**

Ensuring accountability as expansion occurs is essential. DMH continues to emphasize MHSA performance measurement at three levels: 1) individual client level, making sure changes are improving the lives of clients, 2) mental health program or system accountability level, making sure the systems are doing what they said they would do, and 3) public or community-impact level, reducing stigma, for example.

Key contributors to the performance measurement process include the following groups: the OAC Measurement and Outcomes Committee, DMH Performance Measurement Advisory Committee, which does the technical work of developing what kinds of forms and surveys will work in all counties, etc., State Quality Improvement Council, and the Mental Health Planning Council.

It is critical to be able to monitor information on Full Service Partnerships. When people are receiving intensive services, it is important that DMH know what is and is not working, to target funding most effectively. Data will include history and baseline data, follow-up such as key events tracking (hospitalizations, employment, etc.) and quarterly assessments of services being provided.

One county is already providing Full Service Partnership services. DMH is conducting trainings so that the counties know what to do for assessment. DMH needs a new information system at the State to receive these data and is currently in the review

process. The state government uses a cautious and long approval process to make sure that money is invested well.

### **Stakeholders Questions and Comments**

- What are the criteria for being on the OAC committee for performance? Is the OAC recruiting people already?
  - **OAC Response (JC):** The OAC is working closely with DMH and as a result, incorporated many of the members of the DMH Performance Measurement Committee into the OAC Outcomes Committee. The committee is currently focused on community level outcomes. Staff will check the status of the committee, which is likely to be full, because it was kept small intentionally. The OAC and DMH do not want to duplicate efforts. Criteria for membership will be posted on the OAC website.

## **G. Expansion of Expert Pool**

Tina Wooton, MHSA staff, reported on the Consumer and Family Member Expert Pool. This is a pool of consumers and family members (CFM) who help DMH with different tasks. DMH's Consumer and Family Member Task Force asked that consumers and family members be involved at all levels of MHSA. In October 2005, DMH posted applications for new members. There are now 160 people in the Expert Pool, compared to 71 previously. The pool has provided consumer and family member experts to the ten-member CSS plan review teams. To date, 58 people have been trained to work with the teams, 44 of whom have participated. Other Expert Pool members sit on different committees. Licensing and Certification has used the pool as well. DMH has also trained 26 cultural competence experts and 8 experts in county mental health administration.

### **Stakeholders Questions and Comments**

- Are there people expert in recovery and wellness on the CSS review teams?
  - **DMH Response (Tina Wooton (TW)):** The Expert Pool has a broad perspective on that issue.
- Why is wellness and recovery not included on this list of people who were trained?
  - **DMH Response (TW):** The Expert Pool is comprised of consumers and family members. The cultural competence and county administration experts simply joined the Expert Pool to participate in our training.
- Are there people with a background in transformation on the teams and did DMH provide training to them?
  - **DMH Response (CH):** DMH has tried to recruit people with multiple skills and expertise. It is important to have people with all these skills.

- Among the group of experts who have been assembled, are there any Native American people who have worked with the Native community? How were they gathered?
  - **DMH Response (CH):** For cultural competence, DMH advertised on the website. DMH checked about Native American participation and reported that several of the cultural competence experts were Native American people.
- What is the role of the expertise in recovery on the review teams? You are talking about logistics. In many counties, consumers and family members had less of a role in driving the planning process than the staff. It is a different conversation to say, “How are we doing this?” rather than “Why are you not doing this?” What is the DMH sense of how the Expert Pool is working? What lessons has DMH learned? Has DMH been able to capture the genius of people who have been through it?
  - **DMH Response (CH):** While DMH and counties can always improve, DMH has heard that the CSS review process has been one of the most transformational vehicles DMH has ever used. Everyone works as a team. Staff have a role, but members from the Expert Pool have felt like they have the ability to have input. People are seeing that the process is really working. In terms of everything DMH is doing, this part seems really solid. Concerns include the amount of paper and additional requested information when the counties feel they are ready to move on. Most people seem to feel very positive about it.
  - **DMH Response (TW):** At some of the face-to-face meetings, the team leaders meet with the Expert Pool in advance about their input and use this as part of the screening.
- Increasing the Expert Pool has been incredible. What is the training to review plans? What are they expected to do? You can have the greatest pool, but the content of the training matters. What is DMH asking the Expert Pool to look at?
  - **DMH Response (TW):** The first round of training was pretty quick. Many members of the Consumer and Family Member Task Force and other consumers and family members were involved in the training. It described the review process and also covered the concepts, such as wellness and recovery, patient-centered care and cultural competence that CSS plans need to adhere to. Another training will be scheduled in the fall, with more time to plan and obtain feedback into the curriculum.
- In terms of the Expert Pool, when will it be expanded?
  - **DMH Response (TW):** The call for applications issued in October 2005 had a deadline for training for CSS plan review. The applications that were received after the deadline were submitted to the Contracts Office, which initially said there were no more resources, but has recently said staff is now available to process those applications. Expansion will be very soon, but no date has been set.

## **V. Education and Training Presentation and Small Group Discussion**

### **A. Presentation**

Warren Hayes is the new DMH Chief of MHSA Workforce Education and Training, who began his position in February. He encouraged stakeholder feedback by telephone calls, letters and emails as well as through the General Stakeholder Meeting. This is the beginning of the process for the Education and Training component. The intent of this MHSA component is to develop a program with specific funding to address the shortage of staff to serve public mental health clients.

The MHSA stipulates that California will develop a five-year Education and Training Plan (Five-Year Plan). DMH is responsible for its development, with review and approval by the Mental Health Planning Council and oversight by the OAC. The plan will remain in draft form until an inclusive stakeholder process is completed for all parts of the plan. The plan will be developed incrementally and will allow for public input throughout the process.

The draft, posted on the MHSA website, was shared with the following organizations listed below:

- California Network of Mental Health Clients
- National Alliance for the Mentally Ill California
- California Mental Health Directors Association
- California Association of Social Rehabilitation Agencies
- California Mental Health Planning Council
- California Institute for Mental Health
- United Advocates for Children of California
- Department of Mental Health MHSA Team
- Office of Multicultural Services
- Professional Mental Health Occupations Representatives

The plan is an outline done in a strategic planning format. Stakeholder input on both form and content is sought.

### **Mission**

California will develop and maintain a sufficient workforce capable of providing consumer-driven, culturally competent services that promote wellness, recovery and resiliency, and lead to evidence-based, values-driven outcomes.

### **Core Values** (derived from MHSA itself and MHSA vision statement)

- Promote wellness, recovery and resilience
- Increase consumer and family member involvement and employment in service delivery
- Develop a diverse, culturally sensitive and competent workforce
- Deliver individualized, consumer-driven services

- Outreach to underserved and unserved populations

**Vision Statement** (adapted from a keynote speech delivered by Dr. Mayberg at a recent statewide education and policy forum)

- **Leadership** – recognizes and supports successful individuals, programs and practices
- **Responsive** – is sufficiently staffed to meet CSS workforce needs at all levels
- **Inclusion** – engages all stakeholders, including consumers and their families
- **Fidelity** – curricula need to adhere to the intent of the Act; facilitates ladders from entry level through licensed positions
- **Relevance** – needs to incrementally improve the workforce

DMH, in partnership with stakeholders, will develop an ongoing needs assessment process that will measure workforce need, capacity to meet the need, and provide valid data to facilitate planning both short- and long-term actions to meet the Five-Year Plan objectives.

**Goals** provide broadly defined strategic directions and are limited in number:

- **Goal #1** – Develop sufficient qualified individuals for a diverse public mental health workforce
- **Goal #2** – Increase the quality and success of educating and training the public mental health workforce in the expressed values of the Act
- **Goal #3** – Increase the partnership and collaboration of all entities involved in public mental health education and training

**Objectives** are derived from the legislation itself. These objectives provide a structure to create a realistic set of actions that are matched to assess need, funded, administered and reported as accomplishments.

**Goal #1** – Develop sufficient qualified individuals for a diverse public mental health workforce

- A. Expand postsecondary education capacity
- B. Expand loan forgiveness, scholarship programs and extend these to current employees of the mental health system
- C. Create stipend programs
- D. Promote employment of consumers and family members at all levels of the mental health system

**Goal #2** – Increase the quality and success of educating and training the public mental health workforce in the expressed values of the Act

- E. Develop curricula to train and retrain in accordance with MHSA values
- F. Include cultural competency in all training and education programs

**Goal #3** – Increase the partnership and collaboration of all entities involved in public mental health education and training

- G. Establish regional partnerships within the education and mental health systems

- H. Increase MH career development opportunities within high schools, Regional Occupation Programs and adult education systems
- I. Promote meaningful inclusion of consumers and family members in all training and education programs

### **Next Steps**

- Incorporate stakeholder input on the Five-Year Plan structure
- Develop for stakeholder consideration a draft Needs Assessment Process
- Draft for stakeholder consideration short-term actions to the Five-Year Plan
- Receive and incorporate stakeholder input

Last fall, DMH invested short-term one-time funding into stipends for second year social work students through the California Social Work Education Collaborative (CALSWEC). Now there will be 175 graduate social workers available to provide services to CSS. This is an example of a short-term strategy to increase the workforce.

Input is welcome both today and on an ongoing basis by calling 916-651-0461 or sending an email to [mhsa@dmh.ca.gov](mailto:mhsa@dmh.ca.gov). Information is posted at [www.dmh.ca.gov/mhsa/EducTrain.asp](http://www.dmh.ca.gov/mhsa/EducTrain.asp)

### **Stakeholder Questions and Comments**

- Define the public mental health workforce as discussed under MHSA. Is there any room to train other professionals such as law enforcement or teachers?
  - **DMH Response (Warren Hayes (WH)):** MHSA defines the workforce as the county mental health departments and their contract agencies. It leaves room for collaboration and partners, such as first responders, schools and others. It could be advantageous to have training opportunities available to the community. There could be a requirement or recommendation that communities engage in a process to assess what training is important and to reach out to everyone who can benefit.
- Does this component go broader to the community or is it to have more competent staff?
  - **DMH Response (WH):** In order to reduce stigma, education and training for the public and the workforce is critical. Stigma is a huge part of the role of MHSA and is something everyone wants to address. At the same time, it is essential to put resources into making sure that the workforce is qualified. DMH is just starting on this path and it is important to start as broadly as possible in the definitions and narrow only when necessary.
- Include the whole spectrum of staffing: those in positions already, those preparing to enter, staff at self-help centers, college students, and people who are well-grounded in the current system, such as psychiatrists. If consumers could know if a psychiatrist has been trained in the issues of recovery, resilience, wellness, stigma

and client culture, it would be very helpful. Perhaps develop a certification process in which providers become trained in wellness and recovery.

- **DMH Response (WH):** Education and Training will address positions at all levels, with emphasis on training on the issues of recovery, resilience, wellness, stigma and client culture.
- It is crucial to look at who will fill these jobs. The professional guilds will be able to negotiate for expansion of their programs, which takes time to implement. On the other hand, para-professional consumers and family members can provide a lot of the services and can be quickly trained and ready to work. It is important to move on that now.
  - **DMH Response (WH):** DMH feels an urgency to do something now, and is working on short-term strategies. However, this also must be balanced by developing curricula and programs that address long-term needs.
- It has been said that recruitment efforts for culturally competent staff is national. However, people from out-of-state will not be grounded in wellness and recovery with our transformation mindset. At the same time, our own schools have not been trained in transformation.
  - **DMH Response (WH):** Statewide, the mental health system is lacking sufficient trained, qualified staff. There are a number of strategies to help counties implement their plans. Together, everyone has the responsibility to make sure the services are responsive to the intent of MHSA. At the same time, DMH has to demonstrate leadership to help the counties bring consumers and family members on staff and provide the requisite supports to make the transition to becoming a staff member. DMH needs expertise from stakeholders.
- What is the timeline? When will draft requirements be out?
  - **DMH Response (WH):** There is a tremendous sense of urgency to implement the Education and Training component, coupled with a need for an inclusive process, ensuring that the money is well-spent. The goal for implementation is to have a draft plan ready with all the parts completed and vetted by April 2007. The counties and contract agencies are scrambling to hire positions funded by their CSS Plan. Short-term strategies need to be in place within the next six months to address the needs right now. The transformative work also has to happen. For example, the counties' CSS plans have old-style job titles and specifications; these need to be transformed.
- The counties were offered staff to help them to implement the CSS plans. The counties are ready. There is a lot of "hurry up and wait." Will DMH's Education and Training component help things move more smoothly? When will people be sent to counties to help? When the plan is approved or before?
  - **DMH Response (WH):** DMH is working on the approval process now.
- Everyone tells DMH staff to move faster; for example, Los Angeles County can immediately swallow those 175 trained and committed social workers. Counties

need workforce improvement now or they will start to hire staff away from each other and the richer counties will win. The lack of a sufficient, qualified workforce is a recipe for disaster.

- Is the stipend program short-term?
  - **DMH Response (WH):** This has not been defined yet.
- Stipends for consumers cannot be higher than \$85 per month. The goal is to find consumers jobs, move them off SSI, into the workforce and paying taxes.
  - **DMH Response (WH):** The traditional definition of stipend is funding so that someone can matriculate in an academic program to become employed.
- It would be useful for teachers and mental health providers to collaborate. There is an interesting curriculum from Minnesota to train teachers.
  - **DMH Response (WH):** Send DMH the information from Minnesota. The stakeholder process starts with showing draft documents to leadership from stakeholder organizations to know if the concepts are on track, and then goes to the community for deeper feedback. DMH has identified some leadership from the education community and welcomes input from additional sources.
- For the educational system, the ability to train consumers as mental health workers raises some significant challenges. Mental health clients come in as students as part of their recovery. The mental health system is not effective at being a support to these students, although they have the intention to do so. DMH needs to train mental health workers within the system as well as the education system to work together effectively to support consumers.
  - **DMH Response (WH):** Yes, this needs to be operationalized as Education and Training moves forward. Whenever consumers move to becoming providers, they go through a transition which requires support.
- What is the goal with adult education?
  - **DMH Response (WH):** Adult education is an important resource for the community. It does not require a lot of money for tuition, is community-based and is excellent for people who want to develop specific skill sets.
- Oftentimes small counties experience regional collaboration as the larger counties in the collaboration dominate resources and no money is channeled to small counties. How does the push for regional collaboratives bode for small counties which often pay less for staff? This is also a concern for the northern counties that may not have as many institutions of learning.
  - **DMH Response (WH):** Regional can mean a solution for small counties that allows them to come together with an economy of scale they would not have alone. They may not have an ability to bid on training or staff themselves. In small counties in which communities are so disparate, regional collaborations may allow them to compete, to pay higher salaries and fill positions.

- Sanction checks create a large barrier to employment for many consumers. This includes people who are late in paying their student loans.
  - **DMH Response (WH):** It is important to address this issue.
- Provide more public relations to the underserved, such as a DMH statewide sponsored mental health fair to disseminate information about mental health issues in a timely manner.
  - **DMH Response (WH):** This is an excellent suggestion. The OAC really understands that the work of the MHSA needs to be visible to the public. The people who voted for this act need to know what has been accomplished so far.
- I do not understand having a Five-Year Plan rather than ongoing assessment and plan.
  - **DMH Response (WH):** MHSA stipulates a Five-Year Plan. The intent is to look at workforce with a long term view. This strategic planning process will include ongoing assessment.
- It is appalling that counties are not receiving dedicated workforce training dollars at this time, when they most need it to support transformation through CSS plan implementation.
- MHSA outlined funding for the Education and Training component. This was a good thing, but it has placed counties in a precarious position. Counties need the workforce to absorb the expansions, including consumers and family members to be trained to be culturally competent as well as to staff resiliency programs. DMH should not expect counties to hit the ground running without a workforce. Some of the one-time-only funding should be for training. Counties can then begin the process of transformation.
- It is very important to develop training for professionals working in the mental health system to be able to adapt to transformation, including accepting of consumers as colleagues. Consumers who will be entering the mental health system workforce will not be welcome or successful until current professionals understand the client culture. The whole team needs to work together. Professionals need to understand that even if consumer staff do not have a degree, they can be effective at their job.
- I have lost more care coordinators than I can count. The one I have now is leaving to go back to school. They are not being paid enough and need to go back to school to qualify for higher pay. A whole lot of education is unnecessary; it is what is in their hearts that is important. Mine always had time for me, always gave me hope. If they were paid enough, maybe they would stay in the system.
- Professionals and associates have done so much for me. I would like to be trained to be able to do for others what has been done for me.

- Four times I had to go the emergency room because of panic attacks and the doctor did not know what to do for me. Emergency room doctors need to be trained to know what to do with people having panic attacks.

## **B. Stakeholder Comments about the Draft Education and Training Five Year Plan**

Stakeholders provided written feedback during the general stakeholders meeting about each component of the Draft Education and Training Five-Year Plan.

### **Vision**

#### ***Content Issues***

- The vision statement is poorly written. Please start over. (2)
- The vision statement should be a stand-alone document. The additional language, which was read aloud, should be incorporated into the written document because it clarifies the intent of the existing language.

#### ***Additions***

- Add visibility of services: people need to know where to ask for help.
- Vision should include a body-mind-spirit approach to mental health care.
- Add families, caregivers, education, employment, functioning in society, respect, cultural and financial needs.

#### ***Leadership***

- Leadership encourages innovation aimed at transformation of the system to meet consumers' need for recovery and resiliency.
- Prepare a younger generation for leadership, with field trainings in the community before attending college in the mental health field.
- Advocate at all levels of government to promote a saner socio-economic environment, including living wages for all, universal health care, free education, etc. People living under sick conditions become sick.

#### ***Fidelity, Inclusion and Responsiveness***

- Under "inclusion" add "particularly those from underserved communities" after consumers and their families.
- This piece is far behind. Counties will have problems being sufficiently staffed in the near future. Developing training programs needs to be top priority; at least some early funding and support are needed as soon as possible.
- Fidelity and intent: How do counties help those who do not know they want services? Involuntary services exist now: in jails and prisons.
- Nothing in Proposition 63 as presented to voters said treatment is only voluntary.

## **Mission**

### ***Consumers and Family Member Focus***

- The Mission Statement seems to contradict the Core Values. It does not include families. Please change to read “consumer and family-driven.” (4)
- Add “intergenerational consumer and family-driven.”
- Add “consumer and family-driven”: family members speak for young children.
- Add section in quotes: California will develop and maintain a sufficient workforce, “including consumers and family members,” capable of providing consumer-driven, culturally competent.

### ***Cultural Competence***

- Develop a workforce that hires consumers, family members and people of diverse ethnic and cultural backgrounds at all levels of the mental health system.
- Sensitivity training; dignity and compassion; training for professionals.
- Add “culturally and linguistically competent.”

### ***Evidence-Based and Values-Driven***

- Use more descriptive wording than “evidence-based” or “values-driven” or “outcomes.” Not sure what this means. (2)
- “Evidence-based” should refer to services rather than to outcomes. Services have evidence that they produce outcomes.
- Outcomes are client satisfaction and community inclusion.

### ***Additional Concerns***

- Add “Help with rent.”
- Workforce appears to be the mission rather than serving of people in need.
- Add education, respect, functioning, anti-stigma, employment and empowerment.

## **Core Values**

### ***Core Value: Promote wellness, recovery and resilience***

- Transformation and prevention must be included as core values.

### ***Core Value: Increase consumer and family member involvement and employment in service delivery***

- Families are co-survivors.
- No one knows mental health life, successes or failures better than a consumer or family member. Utilize consumers and family members as teachers.
- Leadership should be consumers in all counties and families, not staff.
- When hiring for the plans, make sure that there is a client on the selection committee at all levels in the county. Add: “Inviting broad community involvement in creating and implementing strategies to build usable programs.”
- How will clients “in the system” be protected from on-the-job discrimination? How can clients as a group be brought together to develop a system of ethics to protect clients who are working?

- Staff in community-based agencies need to be compensated at the same level as county and state employees.
- Retaining employment while training with DMH for a position with consumer involvement.
- The wording and focus of this element leaves clients with the impression that their education is of no value. All it appears to do is “allow” clients to become educated in this one narrow area and put them to work. Where is education?
- I work at Serna Village, two blocks from the site of today’s meeting. Nearly all of our staff have been consumers. Stop planning to death and “just do it!”
- Change verbiage in current county positions for consumers if they desire a position of employment.
- Include benefit specialists in all departments.
- Stipends and scholarships need to be adequate for students so that they do not have to get loans. (2)

***Core Value: Develop a diverse, culturally sensitive and competent workforce***

- Training of monolingual consumers takes longer; thus more time should be granted.
- The highest priority of funding for stipends and scholarships must be to fund cultural and linguistic competency.
- Cultural and linguistic competency standards need to be established.
- Thank you for emphasizing “a diverse, culturally sensitive and competent workforce.” You cannot have cultural competence with all white staff or consumers.
- Post-secondary institutions must be reviewed to ensure that their training and classes address language and cultural competencies.
- Cultural competencies should be standardized across the state, including education institutions to ensure consistency of accountability and the likelihood that practices will be similar statewide, as the population of people with severe mental illness may move frequently.

***Core Value: Deliver individualized, consumer-driven services***

- Add family members and consumer-driven.
- Need to infuse “family-driven” language from the children’s system of care perspective in the mission statement and the core values.
- Survey consumers to find out their background, gifts they have to offer, and if they wish to work in this field.

***Core Value: Outreach to underserved and unserved populations***

- Add “and ‘inappropriately’ served.” (2)
- Easy access to legal services: maybe a counselor to work with consumers.
- Include pro bono law services.
- The community: they have already been doing the outreach.
- Use community-based organizations and make it easier for them to apply for funds to implement programs. Usually funding goes to the experts in applying for Requests for Proposals (RFPs), not necessarily to experts in case management,

treatment and diagnosing in the community. Community-based organizations are the experts.

### **Content Concerns**

- Some of these core values should be expressed as goals.
- Please include clinical competence as a value. Possibly use another term for clinical, such as expert.
- Priority must be given to community-based programs, which integrate training and education with their services.

### **Goals**

#### ***Goal #1 – Develop sufficient qualified individuals for a diverse public mental health workforce***

- Make sure each person before employment to a mental health program takes a NAMI program on “how to treat people with dignity.” All agencies should do this: Housing, Social Security, etc.
- Help Human Resources Departments within counties.
- Include certification components for peer counselors as well as wellness and recovery facilitators.
- Peer support specialists should be on various accrediting agency boards.
- Peer support specialists should be hired as teachers for mental health aide accreditation courses at the college level.
- Incorporate holistic approaches in care: meditation, affirmation. One cannot fix the body and mind without working on the spiritual side.
- Provide ongoing support for consumers to help retain their jobs.
- Provide scholarships for families and consumers.
- Add: “Increase the number of individuals who have or have had a lived experience with mental illness.”
- Educate and train family members and consumers in passing the civil service test.
- How do I get from being a homeless mentally ill person to a productive member of society?

#### ***Goal #2 – Increase the quality and success of educating and training the public mental health workforce in the expressed values of the Act***

- Not only the workforce, but the entire community needs to be trained and/or educated about the values of the MHSA and to decrease stigma.
- Mental health directors must embrace the goals and need special training in welcoming clients and family members into the workforce. They must model transformation.
- Client culture includes components that contribute to clients’ betterment, status quo makes them worse.
- Create a variety of consumer supports so they can succeed in jobs, e.g., support groups, job coaches and financial stipends.
- Include linguistic and cultural diversity in workforce development goals.

- Teach about domestic violence in school along with sex education.
- Stop anxiety, depression, addiction, etc. before they occur.

***Goal #3 – Increase the partnership and collaboration of all entities involved in public mental health education and training***

- Identify vocationally motivated consumers and link them with community partners. Use these linkages to foster the development of regional collaboratives of mental health staff, consumers, family members and partner agencies.
- Non-traditional and traditional curricula can be developed at the state level for use in the public domain.
- Develop partnerships with established institutions (community colleges, universities) that will provide a vehicle to deliver the new curriculum, as well as non-degree programs.
- Ensure that primary care providers in community clinics are included in the training process and resource allocation.
- All state and local partnerships should be trained by NAMI.
- Build partnerships with many agencies, e.g., law enforcement, Housing Authority.
- Include outreach to parents; training and day treatment for at-risk youth; media outreach to general public; anti-stigma campaigns and training; and outreach to all multi-ethnic agencies.

***Additional Goals Suggested***

- Goal #4: Increase the capacity of first responders to be effective gatekeepers and to collaborate with mental health service systems.
- Goals 1 – 3 are too staff-oriented. Add a goal that incorporates the idea of a mentally and economically healthy community, region and state. Or some other statement of the broader goal.

**Objectives**

**Goal 1 Objectives**

***A. Expand postsecondary education capacity***

- Objectives A and B: How quickly can these be expanded? Attaching some timeframes to these goals and objectives will help support movement towards achieving them.

***B. Expand loan forgiveness, scholarship programs and extend these to current employees of the mental health system***

- How can a student loan be forgiven?
- DMH should communicate with the Social Security Administration (SSA) immediately in order that consumers with mental health or substance disorders can earn more income and make a living. Many clients are afraid of losing their SSI benefits so they are not encouraged to return to the workforce.

**C. Create stipend programs**

- Promote families as volunteers with appropriate education and stipends and scholarships.

**D. Promote employment of consumers and family members at all levels of the mental health system**

- Promote consumer and family member employment in areas related to mental health outside of the system as well.
- Add “Employ consumers and family members in the mental health system.”
- Substantially increase, with a measure of 25% in 5 years, instead of promote consumer and family member employment.
- Flexible and/or part-time employment can help family members to work in the mental health field and still meet obligations for one’s child’s school, therapy and home life needs.
- Counties need money now to develop consumer and family member workers and to educate existing staff (consumers and family members and non-consumers and family members). CSS money does not stretch that far. Core budgets are broken: give them money now.
- Change job descriptions and job classifications.
- Make successful programs and models better known.
- Consumer employees need ongoing support to help maintain working life, recovery and resilience.
- County and state government should open more entry level positions for recovery. If consumers are able to do the job, they should only need the opportunity.
- Clients in recovery need reasonable accommodations to be successful in their positions. Accommodations include time off for physician appointments and space for emotional ups and downs. Recovery from illness is a big challenge; accommodation given by the providers or employers to consumer providers is very important for success.
- What can we do to help them until they are able to take care of their student loans, etc.? What information do we give to them as far as preparing them for the outcomes? How to keep them empowered and hopeful?
- Sanction checks need to be changed. Consumers and family members cannot even volunteer at this point if they were ever late on a loan payment within the last ten years.

**Goal 2 Objectives**

**E. Develop curricula to train and retrain in accordance with MHSA values**

- This needs to happen first. It should be a high priority to do this sooner rather than later.
- The highest priority for residency and internship programs must be for programs, which are culturally competent, and for inclusion of alternative medicine.
- Identify key first responders and gatekeepers for different populations (e.g., youth, elderly, homeless, etc.) and work through their pre-service and in-service training systems to include training in mental health.

***F. Include cultural competency in all training and education programs***

- Change Medi-Cal billing to include cultural brokerage, cultural interpretation, and translation.
- Provide inclusive programs that focus on recovery for consumers, family members and people representing linguistic and culturally underserved communities rather than distinct and separate training programs for consumers, family members, and linguistic and culturally underserved communities.
- Promote reciprocity of mental health providers from other states who are “qualified” including psychologists, psychiatrists, marriage and family therapists (MFTs) and licensed clinical social workers (LCSWs). “There must be at least ten states that are as good as California.”

**Goal 3 Objectives**

***G. Establish regional partnerships within the education and mental health systems***

- Besides establishing regional partnerships, review existing regional partnerships to see where to eliminate duplication.

***H. Increase mental health career development opportunities within high schools, Regional Occupation Programs and adult education systems***

- Develop VISTA-like internship programs with educational support and mentorship support which would allow prospective staff to be placed in positions in schools, community centers, EAP programs, crisis intervention agencies, senior centers, group homes, etc. Provide college credits for this experience.
- Have one- or two-year programs at community colleges and adult schools to train mental health providers who will stay in rural areas.

***I. Promote meaningful inclusion of consumers and family members in all training and education programs***

- Include consumers and family members in all training and education programs.
- Inclusion should refer to: 1) current and future workforce, 2) viewpoints and experiences, 3) trainers, 4) developing and overseeing curricula.
- Address stigma and discrimination, changing attitudes and beliefs.
- Employ consumers at all levels of education and training.

***Format Issues***

- The objectives should be a stand-alone document. The additional language, which was read aloud, should be incorporated into the written document because it clarifies the intent of the existing language.

***Other Issues about Objectives***

- Try to keep in mind the limitations of county government, especially small county government, when deciding what changes to implement.
- Roll out Education and Training incrementally so that mental health providers will be available as soon as possible to staff CSS.

- Where in this process are DMH and counties tracking what has happened to consumers in the MHSA process? If this is tracked, it will lead to real transformation in the areas of stigma and cultural competency. Bridge the class gap between providers and consumers. Consumers are excluded from real decision-making and tokenized on all levels. The best way to relate to the blind is to try on the blindfold. Perhaps providers need to try it on.

## **C. Small Group Discussion**

Participants divided into small groups to address the following issues in Education and Training. The responses from the meetings in Orange and Sacramento are combined.

1. Expand model consumer training programs to facilitate that individuals with consumer and family member experience be hired in public mental health positions at all levels, and have the supports to retain employment.
2. Provide support to form collaborative regional partnerships throughout California among mental health agencies, educational entities and other community programs to address diversity and language proficiency needs in filling positions and educational and training opportunities.
3. Establish loan forgiveness, stipend and/or scholarship programs to competitively recruit and retain individuals.
4. Expand residency and internship programs that have a commitment to cultural competency and the principles of wellness, recovery and resiliency for hard-to-fill positions.
5. What other actions could be undertaken right now that could assist in obtaining and supporting the workforce that we need to implement programs funded by MHSA?

**Expand model consumer training programs to facilitate that individuals with consumer and family member experience be hired in public mental health positions at all levels, and have the supports to retain employment.**

### ***Specific Program Models***

- NAMI has wonderful resources to use as models, including the Family-to-Family, Peer-to-Peer program, Provider Course. (4)
- NAMI's Family-to-Family program could be taught in colleges so students could help.
- Pasadena City College has a program with Pacific Clinics to bill Medi-Cal that can be duplicated for getting consumers and family members into the workforce.
- Adopt the Ticket-to-Work Program for people on disability. It is a federal program, through the Department of Rehabilitation (DOR). It allows people to start to work while they maintain benefits. (2)

- Does the PASS Plan Program still work? It is also from the DOR and provides supports to help people get back to work. Going back to school is also included in the PASS Program. (2)
- Federal job training programs were focused on getting people into private sectors. Learn from these. Subsidies should be improved. (CETA, JTPA, etc.)
- New kinds of consumer-provider trainings such as SPIRIT training in Contra Costa County as a training model for advocacy, peer support and self-help in a client-run center and BestNow in Alameda County could be replicated in other counties. Sometimes as many as two-thirds of trainees get hired. (3)
- Consider programs as models such as Stamp Out Stigma (SOS); Solano AA in high schools; In Our Own voice; senior volunteers, Marin County Peer Provider.
- Stigma and discrimination are the biggest barriers; develop anti-stigma messages.
- DMH and the Rehabilitation Cooperative Program presented their tracking program, where benefits counselors report on people's success after the 90-day employment period. They track the age, ethnicity and new employment, whether people are receiving benefits, among other information.
- "Metacourse" in Phoenix is a good program.
- Pacific Clinics in Riverside is a good program.
- The State Family Resource Center program has developed core competencies for consumer employees. Use what they have done.
- The Mental Health Association (MHA) has a peer counseling program for consumers.
- Look at Coastline one-stop programs.
- Consumers and family members can work in a social rehabilitation facility. There is a certification, Certified Psychiatric Rehabilitation Practitioner (CPRP), for this kind of work. The main criterion for hire is the ability to work with people and they provide extensive on-the-job training. Workers include people in school working on doctorates and consumers working together as a team. It is easy to do and rewarding work. The CPRP is a nationally recognized certified classification, which allows consumers and family members to start to work. It was established in 2000 and is recognized by 11 other states, although not by California. It is adaptable to individual circumstances of education and life experience.
- Provide peer train-the-trainer programs, so that peers can be trained. Peer leaders should get paid to provide the trainings.
- A foster program provided workforce training on a college campus, with a scavenger hunt to help students orient to the campus.
- Consumer-run classes and training programs are worth replicating.

### ***Job Descriptions and Requirements***

- Identifying particular jobs as "consumer positions" or "family member positions" marginalizes people and creates glass ceilings. A position is a position and consumers and family members should be afforded the same respect as anyone else with the skills to occupy it.
- There have been objections to language in job descriptions that identify people as consumers. Be aware that a precedent has been set demonstrating that when

people self-identify as peers to a particular group, their confidentiality has not been violated.

- Counties should give weight to experience (as a family member or consumer) as much as they do to education. Sometimes experience is a better teacher than a degree.
- Change job descriptions, classifications and requirements for types of education and training; clients and family members do not always have the same type of training, but still have the experience necessary to fill these jobs.
- Regarding the new consumer-driven programs, which need program staff who are consumers and family members: what is the process for civil service designation?
- There are huge bureaucratic barriers to change at the county level to alter all these county job descriptions. Could there be some kind of statewide change in the classification systems so that each county need not spend so much time, money and energy making these kinds of changes?
- Consumers and providers should provide trainings together; this strategy accomplishes the training need, changes relationships between consumer and professional providers and provides more part-time compensated positions.
- Address the mental health system language and revamp clinical documentation requirements; the current status is not reflective of transformation or of the values of client-driven, client-focused systems.
- Ask counties to take their job descriptions apart to examine which ones really need to be licensed and which can be done by peers. Ask counties to redo their structures.

### ***Coaches, Champions and Advocates***

- Administrators should be cheerleaders and champions.
- Consumers need ongoing support, not just training and a job. There should be provision of ongoing medication monitoring, help educating employers, and job coaches to help people through everything that comes up.
- Identify mentors for consumers and family members employed in the system.
- Help people to identify their own strengths and what they can contribute. Have staff available to help draw people out so their gifts can be well-used.
- Job coaching is important.
- Supportive education programs need to include helping people to get through college orientation days, registration, and filling out paperwork.
- Provide ongoing support through a one-on-one coach who can help problem-solve all the barriers and challenges that come up during a person's employment.

### ***Benefits Support***

- SSI is very restrictive in terms of earning levels. DMH needs to communicate with SSI to change that system so that people can earn more and keep their benefits.
- The very first thing to do is have a potential consumer employee meet with a knowledgeable benefits counselor to find out if valuable benefits will be lost by working.
- Many consumers want to work, but are afraid to be cut off from their benefits. When people start to be paid, the fear of illness resulting in their not being able to work is

powerful. This can be a problem for consumers who are not able to advocate for themselves.

- Hire consumer advocates who can help people with benefits counseling. This will keep people from moving backwards and help people stay healthy and able to work.
- Consumers need benefits consultation.
- I work part time and get SSDI. I want to be a consumer staff person. What step do I take next? School? How do I make the transition from receiving benefits to being an employee? I could go full-time, but I would lose my benefits and go off my medications.

### ***Financial Support***

- Pay decent salaries.
- Provide paid positions for young adults if their voices are truly valued.
- Make it financially possible for consumers to access education; the cost of living in regions of California comes before the cost of training.
- People living on very low incomes can lose everything when small changes, such as a rent increase occur. Losing housing can lead to losing a job. Have a link for assistance for rent expenses that marries housing with employment.
- Think about living wages for full-time jobs in order to decrease stress for consumers who are already vulnerable to stress. This is a set-up for failure.
- The Expert Pool panel is paid pitifully: \$10 per hour is not acceptable.
- Provide equal benefits for all workers, e.g. 'new' mental health staff.

### ***Additional Supports***

- Assure people access to medications while they are working.
- The threats to clients at work without supports are problematic. All these issues related to stigma and discrimination in the workplace need to be resolved. The Client Network needs to take leadership on this.
- The mindset appears to be that everyone can go back to work full-time. That is not realistic for everyone. Some people can only work limited hours but need to be involved in a meaningful way.
- Increase the opportunities for young people with mental illness to become successfully engaged with higher education and productive work; colleges need to offer appropriate supports.
- Train psychiatrists to recognize that clients need to be seen at flexible hours or after hours, including parents who cannot always take off work in the middle of the day to bring their children.
- Give consumers and family members access to legal resources.

### ***Group Support***

- Create evening support groups for consumers working in the public mental health system.
- Los Angeles County has a client-provider association, which might also work to support family member providers. It supports people employed in the field through:
  - Weekly anonymous support groups held in neutral locations after hours and led by a peer

- Quarterly half-day skill development workshops
  - Identifying systemic issues and bringing them to administration for resolution
- Have client staff support groups in every region and training for other staff to learn how to be supportive.
- Consumer and family member staff need to have their own support groups. This is a programmatic issue. They should also meet with licensed clinicians. The education people can be part of it, but there ought to be a work-study component for licensed people. Consider a requirement that licensed professionals must help provide support to consumers and family members in employment.
- Include not just providers, but receptionists and administrators in this support group environment.

### ***Workplace Support and Flexibility***

- Add “Child care, child care, child care” so that half the species can participate in employment.
- For parents of children with emotional disturbance, have flexible funding around day care.
- Rather than singling consumers and family members out as needing special support, support everyone in the way they need regardless of what their issues are. An EAP program is the classic way to do this.
- Have flexibility in hours, shifts and workplace (ability to work from home) to allow people with psychiatric disabilities to remain in the job.
- Accommodations are important, including flexibility in the hours scheduled for work.

### ***Consumer and Family Member Employment Issues***

- Prioritize consumers and survivors for active recruitment for hiring.
- Design credential programs for consumer and family member training so consumers and family members can have real, salaried jobs.
- In the rush to hire more consumers and family members, there is concern that counties may be creating a second class staff person. While there is value in peer supporters, equality will only happen when consumers and family members are employed in regular positions. The system needs training programs, so that consumers and family members become more than ‘go-fers.’
- Open more entry level positions for consumers in recovery.
- Hire consumers.
- Hire consumers to be translators at meetings instead of the expensive professional translators.
- Employers need to accommodate flexibility.

### ***Consumers and Family Members as Trainers***

- Utilize consumers as trainers.
- Have a trainers’ bureau for people who are already employed. People can go out and role model to consumer groups and to traditional providers to show that MHSA can work.

- In terms of consumer and family member training, the state has substantial depth and breadth.
- Involve consumers and family members throughout every level of education and training, of all types of staff, including physicians, licensed professionals and consumer support staff. They should be used directly as trainers and in developing curricula. This inclusion and emphasis works in several ways, by changing viewpoints and diminishing stigma.

### ***Other Consumer and Family Member Issues***

- Recognize significant class distinctions in socioeconomic status, even among client and consumer groups, that are barriers to recruiting and retaining adequate diversity and representation of the full range of consumers.
- My 13-year-old son knows I take medication and have been in the hospital: he needs supports. I got him involved in volunteer work. I want him to be more aware of what his life is going to be like, so that he can be self-aware.
- Seniors need education. It is about quality of life.
- It is important to have people who care for consumers provide services.
- Protect people who are vulnerable.
- Use people who have recovery and wellness ingrained in them.

### ***Partnerships***

- “Schmooze” the county’s central human resources department to get appropriate job descriptions created. They have not been transformed like county mental health has.
- For counties with unions, it is essential to work with the unions for transformation. The system needs flexibility.
- DMH needs to change Medi-Cal codes to capture the revenue for the services provided by consumers and family members.
- SSI can be flexible if they are kept informed. The issue is whether the consumer is still considered disabled. SSI farms out that determination to the Department of Social Services (DSS). DMH should work with DSS to address this issue.
- Maintain and strengthen partnerships.

### ***Accountability***

- Consider measurements for accountability for each of the five years of the plan. For example, each of five years, increase by five percent the number of consumers and family members hired as staff within county programs so that within five years, there would be an increase of 25 percent.
- Consider measurements for accountability: retrain existing staff in recovery and resiliency. Establish a basic curriculum, and then train 20 percent per year so that by the end of 5 years, 100 percent of existing staff will be trained.
- When making requirements, look at percent of consumers and family members on staff.
- Make it mandatory that contractors hire consumers and family members.

### ***New Models***

- Create family mentorship programs. Family members would become staff members of mental health departments with the role of training other family members in skills such as medication management and communication skills, in order to be able to work with their loved ones in their homes.
- Peer support specialist positions should be established throughout the state, because they have such a positive opportunity to help in recovery. At the same time, train current staff to understand the role of this position.
- Provide executive level leadership and policy training for consumers and family members. A lot of people know a little bit about it, but more training would provide a career ladder.
- Develop training for consumers to help leverage transformation. Provide leadership skills for consumers through regional trainings throughout the state.
- Within each region, identify best practice programs. Create a network of community support for programs.

### ***Cultural Competence***

- In order to implement CSS in a culturally competent manner, counties need to bring in promotores. Set a goal for the number, for example, 2,500 promotores trained as community health workers and cross-trained in mental health.
- Many current staff have many skills but do not have language or cultural competence: this might have as much of a pay-off as other methods. Balance retraining with recruiting.
- Should cultural competence training be statewide or should every county do it themselves?
- Train current staff on recovery and client culture.
- Learn from consumers:
  - What is their culture?
  - What aspects of that culture propel them into success?
  - What aspects maintain them? Impair their progress?

### ***Training***

- Provide more training opportunities for para-professionals.
- Provide on-the-job training for current para-professional staff.
- Identify the core competencies for consumer providers as well as the key elements of peer support and then develop regional trainings around those two things so that counties can begin to employ these key support people.
- Require trainings that bridge the gap between consumers and family members and other employees.
- Contribute to the workforce.
- Develop an academy to train consumers.
- Address and make modifications in the process or scoring of the civil service exam, or provide training to take it, in order to reduce barriers.
- Have monthly or bimonthly classes for consumers and family members, like a job club, to help them meet specific soft skills, such as workplace management, getting

to work on time, how to have a doctor's appointment without taking the whole day and how to be the type of employee an employer would want.

- Non-traditional training programs can lead to employment opportunities.
- Retrain existing administrators and staff.
- First priority should be to train existing staff in how to deal with the mentally ill in a transformed way. Administrative attitudes need transformation.
- Develop mechanisms for future training of consumers and family members when in the workforce.

### ***Outreach***

- Invest in outreach for consumer programs; what outreach mechanisms are planned for communities, counties, regions and the state?
- What will the advertising and recruiting be to reach potential employees?  
Consumers and family members are not hearing about these other jobs. Many are able to be para-professionals, but do not know what is available.
- Priority should be to reach under-served communities.

**Provide support to form collaborative regional partnerships throughout California among mental health agencies, educational entities and other community programs to address diversity and language proficiency needs in filling positions and educational and training opportunities.**

### ***Partnerships***

- Partner with the community college systems and the California State University system.
- Tap into existing regional partnership structures (e.g., city councils, educational administrator partnerships) rather than add more bureaucracies.
- Use existing community structures (Housing Authority, human service agencies) to recruit and train.
- Provide on-site sensitivity training to mental health and housing agencies.
- The Employment Development Department should be a partner.
- Use the mental health system to organize stakeholder input into trainings and programs.
- The Department of Rehabilitation is an important partner.
- Investigate partnering with hospitals with psychiatric training programs.
- Graduate schools already have quasi-partnerships with training sites for internships; build on these existing structures to formalize and make partnerships more permanent.
- Utilize volunteer programs, senior centers, religious institutions, pre-retirement workshops and community-based organizations to recruit and train para-professionals.
- Work more with the public educational system to reach into high schools before graduation to inform students about career opportunities in mental health services.
- Partner with all the training and education agencies, colleges and graduate schools to assure that consumers and family members have access and influence in the role of trainers.

- Establish places to get help for maneuvering the community college system that are staffed by students.
- Go back to high schools and middle schools to look at labeling practices and the impact labels have in sidetracking students away from academic settings; while the government mandates special education for those with less ability, students who are very bright with behavioral or mental health issues are just dropped.
- How can these ideals be achieved given the general education and funding crisis in California?

### ***Geographic and Density Issues***

- Two-thirds of the state's population lives in Southern California. Los Angeles with 10 million people needs to stand alone. Then think about natural collaboratives: no one is going to drive across Los Angeles in the morning or evening. Possible regions could be Orange and San Diego; Riverside and San Bernardino which is a natural grouping, although they are so large geographically; Ventura, Santa Barbara and Kern.
- The Bay Area model will not work in Southern California.
- For small counties, there may be value in working with larger counties, which are addressing the issues, to share ideas and stop duplication. Partnerships will save money, time and energy. Even colleges in small counties are not as up-to-date as they ought to be.
- Rural counties should partner with each other to develop rural services specialty programs.
- Develop plans for regions without educational institutions.

### ***Training and Training Curricula***

- Provide incentives and opportunities to reward counties and cities that provide joint training and jobs programs.
- Expand and replicate programs like Pacific Clinics and Pasadena City College's 16 week "Para-professional training program."
- Ensure that these kinds of training programs are provided in local community colleges; otherwise potential staff go to other areas where they can get training.
- Infuse curricula with real diversity and real range of experience (look at the Smith College of Social Work program as an example).
- Consumers and family members can teach psychiatrists and institutions about recovery and transformation. Develop a team to go to their annual meetings and conferences to train them there. Start at the top.

### ***Outreach***

- Develop outreach groups of consumers and family members to provide education to all the partners.
- The motto for regional partnerships should be "persistent non-threatening outreach and engagement."
- Include older adults as an outreach priority, targeting retired persons as potential for expanding the workforce.

### ***Credentialing***

- Modify human service credentialing options so that there is not such a heavy emphasis on graduate school; expand the range of training options in the continuum between a 16-week credentialing course and Master's level certification; there should be a fuller range of post-high school level training programs and jobs.
- Evaluate and identify alternative models and alternative credentialing in order to utilize client and family member skills and strengths.

### ***Technology***

- Leverage technology such as teleconferencing, internet, etc.
- Look at NAMI's religious faith network outreach.

### **Establish loan forgiveness, stipend and/or scholarship programs to competitively recruit and retain individuals**

#### ***Stipend Eligibility***

- Provide stipends to transitional age youth to present programs such as Stamp Out Stigma (SOS).
- Provide stipends at all levels of education including post bachelors and masters degrees. Do not institute payment ceilings for consumers and family members.
- Offer stipends to existing staff to train part-time in order to keep people in the workforce (e.g., 40-hour work week includes 30 hours of work and 10 hours of school).
- Offer stipends for mental health staff for education and retraining.
- Stipends should be used for certification programs for existing county staff.
- There are MFT programs in Los Angeles County, which offer fellowships for bilingual students; but only half of eligible students apply because the stipend of \$8,000, given the payback requirement, is insufficient.
- If consumers are now employed, can they access stipend and loan programs through MHSA?

#### ***Stipend Coverage***

- Stipends should cover basic needs such as lodging, and per diem expenses.
- For consumers and family members to fully participate in MHSA, provide stipends for communication, traveling and access to the meetings.
- Provide stipends for additional support services to go to school.
- Provide stipends for consumers to volunteer in self-help client-run groups, on warm lines and on crisis lines.

#### ***Other Incentives***

- Offer competitive pay for all positions.
- For people receiving stipends for education, also give them computers and iPods, so they can download lectures. Use technology to improve efforts with an eye to cultural competence.
- Offer incentives to encourage consumers and family members to return to the educational system.

- Consider advance reimbursement of stipends.
- Phase-in and increase stipends as incentives for good grades and continuing education.
- Create incentives for non-English-speaking people to enhance their spoken and written English skills.
- Offer dormitories for students in training to address cost-of-living issues.

### ***Service Obligation***

- Santa Ana requires 100 hours of service per semester covered.
- When considering service obligation, remember that the education itself is important and for some it may not lead to a paying job.
- Some psychiatric residency programs have a service year per year of tuition payback requirement, which is capped at a certain tuition reimbursement level.
- Professionals who go to work in public service jobs could have some portion of their loans repaid over a specific number of years. Any service commitment should be over a longer period of time. Two years is not a long enough commitment.

### ***Loan Forgiveness***

- There is a lack of psychiatrists, especially those who are recovery-oriented. Consider loan forgiveness and loan repayment programs for them and for prescribing nurse practitioners.
- Forgiveness of prior student loans should not prevent access to programs and new opportunities.
- Determine impact of loan forgiveness and stipends on SSI.
- Identify legal issues on loan forgiveness.
- Identify new ways to forgive obligations.

### ***Scholarship Programs***

- Develop scholarship programs for family members. Capitalize on their passion. Spend scholarship money for higher level professional training for them.
- Provide scholarship assistance for living expenses such as childcare, transportation, and other financial barriers.
- CALSWEC provides full tuition for a master's fellowship.

### ***Information Dissemination***

- Consumers and family members need available data and information about stipends and loans.
- When conducting recruitment and outreach activities to schools, talk about the programs and opportunities for stipends, scholarships, etc.
- Utilize culturally competent and appropriate recruiters for outreach and marketing of workforce expansion and training opportunities. Develop a marketing plan, Web site, logo, etc. to disseminate information about training programs, stipends and incentives.
- Provide information about requirements for employment. The Network of Care should include this kind of information on the Web site.

- Provide more public service announcements regarding MHSA and new job opportunities.
- Focus on a plan to get information out about new jobs and training opportunities.
- Provide access to marketing and training online.

### ***Priority for Consumers and Family Members***

- There might be legal challenges to priority for consumers and family members to scholarships and stipends. This should be addressed because lawsuits would draw money away from services.
- Give priority to consumers, family members, and cultural and linguistic minorities.

### ***Other Issues***

- The mental health system is over-professionalized. BA psychology graduates need to be recruited as para-professionals.
- Address compliance regulation issues that create challenges to access loans and stipends. Do not have reverse discrimination.
- Sanction checks are really hurting consumers and family members.

**Expand residency and internship programs that have a commitment to cultural competency and the principles of wellness, recovery and resiliency for hard-to-fill positions.**

### ***Cultural and Linguistic Competence***

- Consider employing foreign trained professionals who can work here on visas. There are high quality people in other countries who could provide services in a culturally competent and linguistically appropriate way.
- Work with international exchange programs to train staff in the cultures.
- Provide more opportunities for psychiatrists from other countries to work in the system.
- Create outreach programs to recruit and develop professionals who are culturally and linguistically competent and understand communities, e.g. Asian Pacific Islanders.
- Partner with ethnic-serving community-based organizations for placement.
- Every student should have a personal relationship or experience with the people they will serve, e.g., travel to a home country should be part of the program so they really understand the culture.
- Immerse students in real life situations such as living in board and care facilities.
- Make training at social work schools relevant: align actual work with the training.
- Emphasize community competence, not necessarily cultural competence. Individual communities have their own cultures; for example, all Latino culture is not the same.
- Cultural competence does not automatically imply language competence; where is the emphasis on linguistics?
- Recognize that institutions have cultures too. Different agencies and professions have their own cultures and we have to acknowledge what this means.
- Recruit U.S. residents with language competence or skills.

- Training programs do not address cultural competency; curricular changes are needed in these programs.
- Client culture is part of cultural competence. Provide training on this by consumers and family members.
- Develop a program inside the Mental Health Department to address staff cultural competence regarding client culture and how to more effectively connect with consumers.
- Identify and develop strategies to better serve youth. Passion and cultural competence are required to work with the youth.
- Socioeconomic status is a cultural competence training issue: economic issues are a large barrier for getting into academic programs. College programs may not be the only answer. Review academic requirements and curricula so that they are reflective of what is needed for the work.

### ***Transformation***

- Where is transformation? Before focusing on expansion, which will continue business as usual, assess what is needed in a transformed system; think bigger than the existing structures.
- The cart is before the horse; “hard-to-fill” positions reflect a status quo consideration.
- Change the system and train the system, incorporating the view of consumers and family members.
- Continuing Medical Education Units (CMEs) should be available for transformation and consumer-run programs.
- Consumers and family members must be trained alongside the professionals.
- Address the ‘elephant in the room’: i.e. stigma. This keeps many consumers and family members from working in the mental health profession.
- There is a disconnect between a professional model of competence as derived from book learning and experiential competence, of empathy and heart.

### ***Wellness and Recovery***

- Make wellness and recovery a required curriculum and part of the licensing exams through the Board of Behavioral Sciences so professionals cannot be licensed without understanding the principles.
- Change curricula through the entire educational pipeline (high school, community college, university, graduate programs) to include wellness and recovery values.
- Include trainings that provide interface with clients and family members; employ clients and family members as trainers in medical schools. Consumer presence could help transform the setting.
- Universities need to update their curricula to include wellness, recovery and resiliency.
- Investigate the “Talking Circle for Invisible People” approach to raising awareness.
- The medical model approach is counter-productive; what is needed is a wellness and recovery approach. Medical model objectives are unrelated and insufficient to address transformation.
- Nurses have not learned the recovery model. They need to understand this process.

### ***Supports***

- Work with community housing projects to consider setting aside housing for internship and residency trainees.
- Provide orientation and support to navigate the community colleges.
- Include information about available community resources and how to find them in professional training programs.
- Support flexibility in programs that develop skills and employ people so that those programs with consumer and family member experience can be successful.
- Give college credits for life experiences.
- Expand definition of residency and internships to include cross-training and mentoring.

### ***New Programs***

- Expansion of residency and internship programs for licensed people is going to be very difficult. Kern, which was the last psychiatric residency program, took 25 years to put together well. UCSF wants to expand a program for people who are from different professions to come together. Residency and internship programs are reliant on supervision, and those people are retiring now.
- It takes a long time to set up internships and residencies: 5-10 years is a realistic timeframe.
- The system needs a variety of levels of internships in two- and four-year colleges and for internships for consumer/peer positions.
- Form collaborations among university, County Mental Health and community-based organizations for mental health internships. Develop VISTA-type programs as an entry point.

### ***After-Hours Incentives and Issues***

- The positions that are hard to fill include child psychiatrists, nurses, swing shift and after-hours mental health workers.
- Expand internship opportunities, internships available in off-hours.
- Consider incentivizing after-hours roles to increase recruitment and retention.
- There are specific types of after-hours care needed; there should be a curriculum developed to train providers in this kind of care.

### ***Partnerships with Educational Institutions***

- Create agreements with training programs to rotate residents and interns through public sector mental health settings.
- Established educational colleges should be at the table with a commitment to curriculum development. Executives in charge of curriculum at universities and community colleges need to be at the planning table.
- Educate staff at schools about program flexibility and support (peer and professional). Utilize consumers and family members to educate school staff.

### ***Credentialing***

- Accreditation should make adjustments for supervision of interns and promote cross-training across disciplines.

- Incorporate consumers and family members' input on accreditation boards.
- Develop a certificate program for mental health workers. Expand to all counties and especially to rural counties.

### ***Additional Training Issues***

- Training curricula need to address issues of power and privilege.
- Provide more training on co-occurring disorders and on the need for medication monitoring.
- Provide more training to develop greater sophistication and awareness of fetal alcohol syndrome.
- We need more one- and two-year programs at the community college level to attract students to work in the mental health field.

### **What other actions could be undertaken right now that could assist in obtaining and supporting the workforce that we need to implement programs funded by MHSA?**

#### ***Training***

- For the Early Intervention and Prevention work, make training available for working with very young children with mental health issues. Providers need to be able to work with the entire spectrum of ages from infancy to old age.
- Consider access to on-line, Web-based training for existing staff.
- Increase access in rural areas through distance education and online learning centers in each of the counties.
- Expand notion of education and training to include working with school-aged and transition-aged youth.
- Youth training is critical, otherwise kids end up in the adult system.
- Is it a good idea to group residency and internships together? Tease them out, to focus on multiple internship issues.
- Train primary care providers to the recovery model. Physical health needs to be included in this, especially in terms of medication management.

#### ***Partnerships***

- Partner with ethnic serving community-based organizations for placement.
- Cross-train with drug and alcohol counselors.
- Conduct training for CalWORKs staff.
- Work with law enforcement agencies.
- Leverage with private companies to offer incentives to invest in the mental health system.
- Inclusion and collaboration across counties are important.

#### ***Funding***

- There should be some one-time funding for short-term solutions.
- Expand the short-term funding prior to completing the needs assessment.
- Fund community-based organizations to hire consumers.

- Invest in development of the mental health services if community-based organizations do not have them.
- Help small counties with the smallest budgets. Clients are lost in the shuffle with no help to develop groups.

### ***Transformation***

- Staff training will not always do it; how can agency staff be trained to interview and hire for empathy and heart?
- The mental health systems are very harsh, not only to consumers, but also to staff who start out wanting to help but get ground down; address the hostile environmental conditions (e.g., caseloads, clinical documentation requirements) that lead to depersonalization.
- Transformation and prevention are absent from these strategies.
- Address burgeoning bureaucracy and make it simpler.
- Eliminate disparities among underserved cultures through increased access to programs.
- Identify psychiatrists who embody recovery and wellness philosophy throughout the state and honor them. Develop an award program for psychiatrists, for AB 2034 programs, and other kinds of staff. Identify those leaders and use them to promote recovery and wellness. At MHSA meetings, clients have expressed ideas but the ideas keep getting lost when translated into state or county language.

### ***Staffing***

- Provide clarity about needs of the workforce.
- Bring in more nurses and licensed vocational nurses (LVNs). Attract them to come into community mental health.
- Improve the appropriate utilization of mid-level providers, particularly nurse practitioners and physician assistants for mental health conditions, particularly in the outpatient setting.
- Staff costs and benefits are high, so use interns to continue to strengthen and build the staff.
- Redefine the view of what a workforce is. Volunteers with stipends and training can be part of the workforce. Place less emphasis on traditional education programs and more on adult education, and short-term training which will allow MHSA to take advantage of the burgeoning group of retiring Baby Boomers, many of whom are bright, socially conscious and willing to stay engaged. Train them!

## **VI. CSS Annual Update**

Carol Hood discussed the CSS Annual Update, which is required by the MHSA. This information is intended to supplement other county reports provided to DMH. The purpose is to provide a brief update on ongoing community program planning and implementation of MHSA. DMH is seeking input on content, length and requirements for the CSS Annual Update.

At the April 25 meeting in Orange, Mark Refkowitz, Director of Orange County Behavioral Health Services thanked DMH for bringing a Southern California meeting to Orange County. He noted strengths of MHSA: DMH did an effective job in the short time they had to provide the mental health stakeholders with a vision of transformation, transparency, inclusiveness, bringing in unserved communities, emphasizing linguistic and cultural diversity; and holding counties accountable, throughout the State.

He then noted challenges:

- While many stakeholders were involved in the CSS process up to the public hearing, few saw DMH comments on the plan and fewer saw the adjustments counties made to meet DMH concerns.
- The document for the CSS Annual Update is too large, not user-friendly and challenging to use.
- It is difficult to have an open planning process. Often counties direct people to their Website, but not everyone has access to the Web. In counties with significant language issues, it is important to find ways to deal with a variety of languages on Websites. While 4,000 people participated in the Orange County process, there were only 2,000 hits on the Website. Websites clearly need to be more user-friendly.

Maureen Bauman, Placer County Adult System of Care Director and a board member of the California Mental Health Directors Association (CMHDA), spoke at the April 26 meeting in Sacramento. She noted that transformation could be seen at the county level. Counties are implementing their plans and continue their stakeholder processes. The stakeholder process helps with county implementation of plans and will be involved in monitoring partnerships, the next round of planning process and furthering system transformation. This will include initiatives to make programs more culturally competent and more recovery-based.

Ms. Bauman noted that in terms of the CSS Annual Update, it is important to keep requirements as simple as possible. Everyone wants it to be transparent. DMH should not ask counties to provide data that can be collected another way, but only ask for critical elements so that counties can focus on providing services.

Ms. Hood then presented the issues raised by the CSS Annual Update requirement: What information should DMH ask for? How long should it be? The CSS Annual Update, required for statute, provides a mechanism for counties to propose changes to programs, and provide specific information required in the county's Three-Year Plan approval. It provides a mechanism for communication between counties and DMH. At the moment, DMH proposes that large counties have a maximum of ten pages while small counties have a maximum of five pages.

The OAC wants the CSS Annual Update to provide data on people who are underserved, inappropriately served or not served and results when they do receive services. Other relevant data could include first break information and what it is really required to provide services.

### **CSS Annual Update Requirements**

- A brief implementation update, which must emphasize the five essential elements: community collaboration, cultural competence, client- and family-driven mental health system, wellness/recovery/resilience focus, and integrated service experiences.
- An update on the continuation of the community stakeholder process. Counties should describe involvement of stakeholders in the update and implementation processes, with the dates of the 30-day stakeholder review period and documentation of the public hearing by the local mental health board.
- Program implementation update by age group: highlight transformational activities to move the system toward the five essential elements. Reports should include the challenges as well as the successes, in order to guide changes at the county and state levels.
- Additional required elements: some counties may have additional reporting requirements as a condition of approval of the CSS plan. Those updates are required with the CSS Annual Update.

### **County Requests for Changes**

The CSS Annual Update gives counties an opportunity to make plan changes based on new information. They can use the update to propose revisions to existing programs, by providing a rationale for changes and a description of them. Counties can propose new programs, as long as they meet the program description requirements in the DMH Letter 05-05. Counties can submit requests for additional one-time funds, if not at their maximum level. The CSS Annual Update should allow counties to revise their programs to make them more effective. Once these changes are approved, they can become part of the performance contract with agreed-upon performance standards so that money can flow smoothly.

### **Timeframes**

Counties are on different timeframes for CSS approval and implementation. The CSS Annual Update poses a challenge because it helps counties most to have it done alongside the overall county budget process, with a sufficient lead time both to know what money will be available next year and to conclude the required stakeholder process including the notice period and public hearing. Initially DMH proposes to tie it to the county start date, six months after implementation. Then DMH plans to have all Annual Updates due the same time, January after the end of the fiscal year. DMH seeks feedback on all these issues.

### **Submission Date**

The initial Annual Update is due nine months after the approved start date, three months after the end of the period being reported on. Counties need to analyze data, write their report, use their stakeholder process, have 30-day public notice process, and then a public hearing. Is three months reasonable to accomplish all this?

## **Approval**

Both DMH and the OAC must review and approve Annual Updates. Any accepted changes become part of the county's performance contract.

## **Additional Feedback**

To provide DMH with feedback on the CSS Annual Updates and other topics discussed at this meeting, find materials at <http://www.dmh.ca.gov/mhsa/meetings.asp>. Email can be sent to [mhsa@dmh.ca.gov](mailto:mhsa@dmh.ca.gov). The phone number is (800) 972-MHSA (6472). The address is: MHSA Team, California Department of Mental Health, 1600 9<sup>th</sup> Street, Room 130, Sacramento, CA 95814. To reach the OAC until it moves into its own offices, send mail to them care of DMH.

## **Stakeholder Questions and Comments**

- Reports need to provide actual numbers, not percentages of people, that the counties have successfully engaged.
  - **DMH Response (CH):** The numbers come to DMH through different sources on a quarterly basis.
- If a county wants to make changes in-between updates, are they allowed to do so?
  - **DMH Response (CH):** Yes. The CSS Annual Update provides a vehicle that reviews the entire CSS implementation including the stakeholders process.
- Does DMH really want all the updates to come in at the same time? It will be a barrage of reports.
  - **DMH Response (CH):** DMH is struggling with this in terms of the next three-year planning cycle. This time the plan submissions have been staggered, which has helped staff to handle the workload. However, counties budget and develop their plans on a fiscal year basis. MHSA funding will need to be on an annual basis that fits into the county budgeting processes. DMH is trying to figure this out.
- A lot of counties did not put actual dates for implementation of their plan. Asking them to commit to a date is challenging, because of the uncertainty of the actual start-up, given the delays in approval and workforce issues. This first Annual Update should provide the actual date activities and services started. Otherwise it would be a waste of time. Then move to a quarterly system.
  - **DMH Response (CH):** When the first plans came in, DMH asked them to guess when the review process would be completed. DMH needs to be clear about timeframes for when plans will be ready to be implemented.
- Keep in mind the expectations of the voters that the state and counties keep moving to implement the program. Also keep in mind the funding flow for counties. It is good to know that counties' budget process is being adhered to. Such timing issues are bogging down the process. County budget offices are shutting down spending. Counties need flexibility on one-time funds and how they are used and whether they

can be carried or rolled over. Counties are encountering these issues and are not sure how to handle them.

- **CMHDA Response (Maureen Bauman (MB)):** CMHDA stays in close contact with DMH to make sure that these issues are addressed. MHSA needs to incorporate requirements and schedules into the structure of county governments.
- Why would DMH dictate the number of pages by county size instead of up to a set number of pages? Expectations are the same, for the most part. Maybe small counties should use smaller words, fonts, etc.
- Requirements use the phrase “shall,” change it to “required.”

### **Additional Comments from the Stakeholders During the General Stakeholders Meeting**

#### ***Stakeholder Process Issues***

- Have translators at these meetings. People with limited English have great difficulty providing input.
- Stakeholders and DMH need a full day meeting to discuss important concerns that were not able to be discussed at this meeting.
- The comment that everything is working pretty well is not what clients are seeing. The mental health system seems to be protected from transformation. Are Native Americans really getting good input?
  - **DMH Response (CH):** DMH is reflecting what it hears. Maybe DMH is not hearing enough regarding the specific concerns from the Client Network. DMH tries to have consumer and family member perspectives heard. The counties are making a bigger effort at inclusion than any system has ever tried. Is there room for improvement? Of course.
  - **CMHDA Response (MB):** From a county perspective, MHSA is an ongoing process so that people can be heard. Everyone can improve. Mental health directors and staff want to participate in any meetings that can help counties improve.
- The stakeholder process at the county and state level has been going anything but well. This process especially reinforces the isolation of people who are shut out on both levels – youth, homeless, Native Americans. It seems like it flops so far. The stakeholder process needs to be transformed. There are widespread reports of exclusions of consumer and family member stakeholders. The Client Network is working on a report about the ways people are being left out of the process in the hopes of preventing the mistreatment of consumers.
  - **DMH Response (CH):** DMH looks forward to seeing the report from the Client Network.

- Many people involved in mental health cannot attend daytime meetings because they work. Many consumers are not here because of their illness.
- It is important to continue the stakeholder process and to support all the people who are working on consumers' behalf, and the people working on MHSA. I want to be part of the process that has been good to me.
- I am truly grateful for these stakeholder meetings. The only thing that could improve it is more people in attendance. It gives me an opportunity to meet with the State and it has a family feeling.

### ***Peer Support Specialists***

- The first group of six peer support specialists trained in California graduated last week after a Herculean effort in Riverside County. They bring support and knowledge to help others with severe mental illness. Most of the group is here today.
- Riverside County's peer support specialists are seeking family members to provide peer support as well. Consumers and family members all need to work together to meet the clients' needs.
- Consumers and family members should take the peer support specialist course, if the opportunity arises. The peer support training allows consumers to look at things from new perspectives.

### ***Involuntary Services***

- Nothing has been said about Assertive Community Treatment (ACT) programs. People say it is trampling on patients' rights to force them to have treatment. That gives them the right to be ignored, humiliated, have their rights trampled, left on the street to die. I have major depression and anxiety disorder. I went into depression after my son was killed. I tried medication, Prozac worked but I would not take it, my family used ACT and it saved my life. It worked and we need it throughout the State. There are thousands who need court ordered treatment.
  - **DMH Response (CH):** ACT is included in AB 1421. DMH decided that MHSA services need to be voluntary. However, there are options within MHSA for assertive outreach, to try to figure out what would be of interest to that person, to try to find ways to link unserved people into services. Another aspect of MHSA allows people who are court-ordered or in conservatorship into some services through MHSA.
- It is a serious concern to many people that MHSA took a stand on the voluntary issue, because there are consumers who need involuntary services.